BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	)	
Mark Anthony Spicer, M.D.	)	**Case No. 18-2013-232559**
Physician's and Surgeon's Certificate No. A 68609	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on June 7, 2019.

IT IS SO ORDERED: May 10, 2019.

MEDICAL BOARD OF CALIFORNIA

Kristina D. Lawson, J.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **MARK A. SPICER, M.D.** **28078 Baxter Rd, Suite 430** **Murrieta, CA 92563-1402** **Physician's and Surgeon's Certificate No. A68609,** Respondent.	Case No. 18-2013-232559 OAH No. 2016061019 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Christine R. Friar, Deputy Attorney General.

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2. Respondent Mark A. Spicer, M.D. (Respondent) is represented in this proceeding by attorney Michael J. Khouri of the Khouri Law Firm located at 24012 Calle de la Plata, Suite 210 Laguna Hills, California 92653.

3. On or about May 28, 1999, the Board issued Physician's and Surgeon's Certificate No. A68609 to Mark A. Spicer, M.D. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 18-2013-232559, and will expire on October 31, 2020, unless renewed.

JURISDICTION

4. Accusation No. 18-2013-232559 and all other statutorily required documents were filed before the Board and properly served on Respondent on May 20, 2016. Respondent timely filed his Notice of Defense contesting the Accusation. First Amended Accusation No. 18-2013-232559 is currently pending against Respondent.

5. A copy of First Amended Accusation No. 18-2013-232559 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 18-2013-232559. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent admits the truth of the charges and allegations in the First, Second, Sixth and Seventh Causes for Discipline as set forth in First Amended Accusation No. 18-2013-232559.

10. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

11. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A68609 issued to Respondent Mark A. Spicer, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

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1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the First Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

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3. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the First Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s)

and First Amended Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), First Amended Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and First Amended Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice monitor shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of practice monitor, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a

notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

5. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and First Amended Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

7. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

10. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than

30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

12. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

13. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Michael J. Khouri. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: FEB-20-2019

MARK A. SPICER, M.D.
Respondent

I have read and fully discussed with Respondent Mark A. Spicer, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 2-22-19

MICHAEL J. KHOURI
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 2/22/2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

CHRISTINE R. FRIAR
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 18-2013-232559

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **MARK A. SPICER, M.D.** **28078 Baxter Road, Ste. 430** **Murrieta, CA 92563-1402** **Physician's and Surgeon's Certificate No. A 68609,** Respondent.	Case No. 18-2013-232559 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California (Board).

2. On or about May 28, 1999, the Board issued Physician's and Surgeon's Certificate Number A 68609 to Mark A. Spicer, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2018, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, in relevant part, provides:

"The Board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct that would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2261 provides:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

7. Section 2262, in pertinent part, provides:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

". . . ."

8. Section 2266 of the Code provides:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

STANDARD OF CARE

9. A neurosurgeon's documentation of the indications for surgery should be concordant and consistent with the radiographic study results. If the neurosurgeon's

interpretation of the radiographic study results varies from that of the radiologist, there should be some documentation to indicate that the neurosurgeon disagrees with the radiologist or that there has been a discussion between the radiologist and the neurosurgeon. In the absence of such documentation, the radiologist's interpretation would be assumed to accurately depict the radiographic results.

10. An operative report must describe in sufficient detail the procedure performed. In addition, it should document any specimens sent for pathology evaluation.

11. Surgery is performed for pathology that is causing an identifiable impairment or pain. Additionally, surgery is often performed for pathology that places the patient at risk for significant impairments.

12. The appropriate treatment of cerebral arterial venous malformations requires adequate radiographic visualization of the lesion in order to understand the vascular architecture, which in turn guides the surgical approach.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

13. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he committed gross negligence during his care, treatment and management of Patients J.S, J.L., and T.V. ,[1] as follows:

Patient J.S.

A. On or about July 25, 2011, J.S., a female, then 80 years old, presented to Inland Valley Medical Center. Patient J.S. was experiencing severe headaches, nausea and dizziness.

[1] Patients are referred to by their initials to protect their privacy rights. The true names are known to Respondent and, in any event, will be provided to Respondent upon his timely Request for Discovery.

B. Patient J.S.' medical history included atrial fibrillation, hypertension, chronic kidney disease, and chronic obstructive pulmonary disease (COPD). The patient underwent a coronary artery bypass in 1988.

C. Upon presentation, Patient J.S. was noted to have a GCS score of 14.[2] Her blood pressure was in the 170 to 180 range.

D. A head CT was interpreted by a radiologist as showing a 4 x 3 cm acute hemorrhage in the right cerebellum, causing a complete effacement of the fourth ventricle. Laboratory studies showed an INR[3] of 4.4.

E. A neurological consultation was obtained from Respondent. He noted that the patient had a GSC score of 15;[4] that her pupils were briskly reactive bilaterally, and that she had critically elevated INR of 4.4. He reviewed the head CT scan.

F. Respondent's assessment was of a medically complex but neurologically intact 80-year-old female status post likely hypertensive hemorrhage into the right cerebellar hemisphere.

G. Respondent determined that surgery should not be performed at that time due to Patient J.S.' elevated INR. Respondent recommended reversal of the patient's Warfarin-induced coagulopathy with fresh frozen plasma and Vitamin K. Respondent recommended a right sub occipital craniotomy for evacuation of the intracranial hemorrhage when the INR lowered to 1.3 or less.

H. The following day, Respondent noted that the patient's INR had reduced to 1.5. He also noticed increased drowsiness which he believed was secondary to increase in hydrocephalus.[5]

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[2]GCS refers to the Glasgow Coma Scale, a neurological scale, used to record the conscious state of a person. The patient is assessed against the criteria of the scale, and the resulting points give a patient score between 3 (indicating deep unconsciousness) and either 14 (original scale) or 15 (the more widely used modified or revised scale).

[3] INR refers to International Normalized Ratio. It relates to a person's ability to coagulate blood.

[4] See footnote 2, *ante*.

I. Respondent ordered a digital subtraction angiogram and another head CT.

J. A digital subtraction angiogram performed on July 26, 2011, was interpreted as demonstrating no underlying or true venous malformation or vascular lesion in the area of hematoma by Dr. JCK.

K. The follow-up head CT was interpreted by Dr. JCS as demonstrating no change in the cerebellar hemorrhage with mild hydrocephalus.

L. Respondent recommended placement of a ventriculostomy for the hydrocephalus. Cardiology and renal consultations were sought and obtained. No significant change in the patient's renal function was found.

M. The cardiologist noted findings consistent with a small myocardial infarction. He recommended no surgery except in the case of an emergency.

N. Another head CT scan, taken on July 27, 2011, showed no significant change. A subsequent repeat head CT scan, taken on July 28, 2011, demonstrated circulation of intraventrical hemorrhage into the occipital horns, unchanged left cerebellar intracerebral hemorrhage, and moderate hydrocephalus.

O. On July 28, 2011, Respondent placed a right frontal ventriculostomy catheter and found an opening pressure of 8 cm of water. He noted decreased mental status with a GCS score of 11, coupled with the increase in hydrocephalus as the indication for the ventriculostomy placement.

P. On the evening of July 28, 2011, Respondent took Patient J.S. to the operating room and performed a right sub occipital craniotomy for evacuation of the intracerebral hemorrhage. Respondent noted "recurrent cerebellar intracranial hemorrhage" as his preoperative diagnosis. However, while performing a corticotomy in the right cerebellar hemisphere, Respondent noted "sudden copious quantity of pulsatile bleeding and venous and apparent from the transverse sinus." A vascular malformation was noted. There was 1300 cc of blood loss.

[5] Hydrocephalus is the buildup of too much cerebrospinal fluid in the brain.

Q. After achieving hemostasis, Respondent wrote in his operative report that he made "the decision . . . not to further explore the corticotomy and attempt to evacuate the cerebellar hematoma. Given the degree of swelling, the incision was closed after copious quantities of irrigation had been used to debride the field." Respondent closed the skin over the defect without performing a cranioplasty.

R. A postoperative head CT demonstrated persistent cerebellar hemorrhage unchanged from the prior studies. A ventriculostomy was noted in the right frontal lateral ventricle posteriorly with interval decrease in size of the ventricles. There was persistent intraventricular hemorrhage along with subarachnoid hemorrhage over both hemispheres.

S. The patient was returned to the operating room on July 28, 2011, by Respondent. However, there was no interval documentation between the first and second surgeries to indicate the reason or rationale for return to the operating room. The first surgery commenced at 12:01 and concluded at 16:37; the second surgery commenced at 20:47 and concluded at 22:33; thus, a period of approximately 4 hours in between the two.

T. In the second operative note, Respondent indicated the indications for the second surgery to be "recurrent cerebellar intracerebral hemorrhage." However, again, the CT did not note a new or recurrent cerebellar hemorrhage. Respondent noted in the second surgery that "the vascular malformation was coagulated using bipolar forceps." It was noted that "there was arterialized bleeding from the transverse sinus, predominantly which had been the cause for the patient's recurrent intracranial hemorrhage." A follow-up CT performed on July 29, 2011, demonstrated an interval decrease in the size of the cerebellar hematoma.

U. The remainder of the Patient J.S.'s hospital course was complicated. She remained neurologically unchanged with a GCS score of approximately 9. She subsequently developed worsening renal insufficiency with elevated BUN and creatine. She developed a GI bleed and became hypertensive. She developed an elevated white blood cell count and was thought to be possibly septic. She was started on IV antibiotics. An EEG was performed by the neurology service, showing diffuse delta activity. Due to

her overall poor condition and declining course, the family eventually elected to make the patient DNR and then subsequently extubated her. She eventually expired on August 13, 2011.

Patient J.L.

V. On September 19, 2011, J.L., a male, then 46 years old, presented to Inland Valley Medical Center with complaints of neck pain radiating into both shoulders and arms. His past medical history was significant for end-stage renal disease, on dialysis, status post multiple AV fistulas, hypertension, and peripheral vascular disease, degenerative disease of his neck, diabetes mellitus Type 2, and left leg sarcoma, status post below the knee amputation.

W. Upon presentation, Patient J.L. stated that two weeks prior to admission, he was brushing his hair when he turned his neck and felt a cracking. Since that event, he reported having neck pain radiating into both of his arms and numbness.

X. His examination was significant for 4/5 strength in both upper extremities.

Y. A CT scan of the cervical spine without contrast was performed on September 19, 2011. This was interpreted by Dr. DRL as demonstrating a lytic lesion involving the left lateral mass of C1 and C2 with a pathologic factor of the left anterior arch of C1. A subsequent MRI scan of the cervical spine without contrast was performed on September 19, 2011. This likewise demonstrated a lytic lesion involving the left lateral mass of C1 and C2 as well as severe spinal stenosis at C2-C3 and C3-C4 due to posterior disc osteophyte complexes and narrowing of the spinal canal. There was no acute cord compression noted.

Z. Respondent, in consultation, saw Patient J.L. on September 20, 2011. Respondent noted that the CT scan demonstrated lytic destruction of the anterior arch of C1 and at the ends of C2. Respondent also noted that the patient did not complain of any new focal neurological deficits. Respondent's examination was significant for 4+/5 strength in the bilateral upper extremities. Respondent recommended an occipital cervical fusion. Respondent then had Patient J.L. cleared for surgery.

AA. On September 21, 2011, Patient J.L. was taken to the operating room for the occipital cervical fusion. Because the anesthesiologist was unable to obtain IV access to induce anesthesia, the surgery was aborted. Respondent, however, did not document in his operative report or in the patient's progress notes that the surgery was aborted or that patient was even taken to the operating room.

BB. The only documentation regarding the aborted surgery is a case management discharge planning note, dated September 21, 2011, at 20:11.

CC. Subsequently, Patient J.L. was taken to the operating room on the evening of September 23, 2011. The procedure concluded on September 24, 2011. Respondent, however, did not document in a progress note or in an operative report, dated either September 23 or 24, 2011, that any procedure was performed. The only documentation of the surgery was an operative report, dictated on October 11, 2011, which showed that Patient J.L. underwent exploration of prior C3 through C7 instrumented fusion, removal of the posterolateral instrumentation from C3 through C7, bilateral C2 through C6 decompressive laminectomies, insertion of an occipital plate, insertion of bilateral lateral mesh and pedicle screws C3 through C7.

DD. Patient J.L. had a largely uncomplicated postoperative course and was discharged to home on October 4, 2011.

Patient T.V.

EE. On December 15, 2011, T.V., a male, then 62 years old, presented to Inland Valley Medical Center for generalized weakness and a seizure-like episode the day before, involving jaw movements and left-sided jerking movements. At the time of presentation, he was noted to be neurologically intact.

FF. A head CT was obtained on December 15, 2011. Dr. DRL interpreted the results and showing "a 2.9 cm mass in the right frontal region which may be extra axial. There is adjacent vasogenic edema in the right frontal lobe. A second lesion with high density focus in it near the vertex of the right frontal lobe."

GG. A second MRI of the brain without contrast was performed, too, on December 15, 2011. This was also interpreted by Dr. DRL as demonstrating two extra axial masses noted over the right frontal lobe with the largest measuring 2 cm in size. The smaller mass measures 2.1 cm in the largest dimension. Both were most consistent with meningioma.

HH. Respondent was contacted for neurosurgery consultation .

II. Dr. VD was contacted for neurology consultation.

JJ. Patient T.V. was placed on Keppra for the diagnosis of a partial focal seizure.

KK. Respondent recommended surgical resection of the masses.

LL. On December 16, 2011, Patient T.V. was taken to the operating room for a craniotomy and excision of meningiomas. Respondent performed the surgeries. A specimen sent to pathology intraoperatively was initially interpreted as being consistent with a high grade glioma. Respondent noted no intraoperative complications.

MM. Postoperatively, Patient T.V. was noted to have a new left hemi paresis and 4-5 strength.

NN. The anesthesia record for the surgeries performed by Respondent indicated a 350 ml of blood loss.

OO. Patient T.V. was noted to be stable on postoperative day 1 with a Glasgow Coma Scale score of 14 and 4+/5 strength on the left side.

PP. On the second postoperative day, Patient T.V. began experiencing neurological deterioration; however, the patients progress record is devoid of any documentation describing this neurological deterioration from Respondent or any other physician involved in the patient's care.

QQ. Respondent's operative report, dated December 18, 2011, but dictated on January 11, 2011, indicated that the patient had a neurological deterioration.

RR. Respondent was contacted in the early morning of December 18, 2011, and informed that Patient T.V. was unable to move his left arm and was significantly obtunded.

SS. Patient T.V. was sent for a stat CT scan. This demonstrated a large extra axial sudural hematoma measuring 2 cm in thickness. There was mass effect with effacement of the nearby right cerebral sulci and compression of the right lateral ventricle. Respondent indicated that there would be "a significant delay in waiting for an operating room of approximately one hour."

TT. Respondent removed Patient T.V.'s staples at the bedside, opened the scalp flap, removed the previously placed bone flap, and removed the epidural hematoma. Respondent identified a bleeding scalp artery, and the patient was taken to the operating room. There, Respondent opened the dura and examined the subdural space and found no bleeding there. Respondent reclosed the dura, the bone flap and the skin.

UU. A postoperative head CT demonstrated interval resolution of the right frontal extra axial hematoma.

VV. In a note, dated December 19, 2011, at 7:30 a.m., Respondent wrote that the patient was extubated and that his left upper extremity monoparesis had improved compared to his status prior to the development of the epidural hematoma.

XX. The patient had some gradual improvement in his left upper extremity strength and sent to physical rehabilitation on December 31, 2011.

YY. Patient T.V., initially, was taken to surgery on December 16, 2011. Respondent's progress notes do not contain a synchronous notation of the surgery. Respondent's transcribed operative report was dictated one month after the surgery was performed.

ZZ. A brief operative note is contained in the patient's medical records but this is not in continuity with Patient T.V.'s progress reports.

AAA. The progress notes of December 17 and 18, 2011, are devoid of any notation of Respondent. There is no documentation of the patient's neurological deterioration except for the second surgery operative report which was dictated on January 2012, at or about the same time the first surgery operative report was dictated. As before, there is only a brief operative note in the available documentation that is not in continuity

with the progress records or in a synchronous position within the progress records. Additionally the format of this is nearly identical to that of the initial brief operative note.

BBB. The following acts and omissions, considered collectively and individually, constitute extreme departures from the standard of care:

1) Regarding Patient J.S., a physician should document within the daily progress notes of the patient's hospital chart the pertinent and specialty specific symptoms, signs, laboratory and radiographic diagnostic data along with an assessment and specialty specific plan of care. Any major deleterious change in the patient's condition should be noted. Significant changes in the patient's treatment plan, particularly a decision to pursue surgery, should be documented, however briefly, within the daily progress notes to facilitate appropriate care, allow other physicians involved in the care an understanding of the plan of care, and to keep an accurate account of the patient's course for medico-legal reasons.

2) Regarding Patient J.S., Respondent's documentation is grossly inadequate. Although in his Initial consultation note, dated July 25, 2011, Respondent noted a recommendation to pursue suboccipital craniectomy upon correction of the coagulopathy. A subsequent note on July 26, 2011, at 13:05, indicates that the patient has a stable intracerebral hemorrhage with increase in hydrocephalus and will need CSF diversion (ventriculostomy). Thus, the indications to pursue surgery are not clearly outlined in any of the documentation. Furthermore, there is no documentation in the progress record of him having performed two surgeries. The operative note for the first surgery was in fact dictated in September 2011, nearly six weeks after the surgery and well after the patient had expired. The operative note for the second surgery was dictated on August 18, 2011, which is approximately three weeks after the surgery and after the patient had expired. Thus, at the time of care it would appear that an uncomplicated single surgery was performed, when that was not in fact the case. Moreover, the cardiologist note from July 28, 2011, at 08:05 indicates that there may have been a change in the mental status after the ventriculostomy placement. The patient was noted to

be unresponsive by the cardiologist. However, there was no documentation from Respondent to indicate a decline in the patient's mental status after the ventriculostomy placement that would prompt emergent suboccipital craniectomy. Based on the timings recorded in the progress record, Respondent had ample time between the placement of ventriculostomy in the first surgery (nearly 3 hours) and between the first and second surgery (nearly 4 hours) to appropriately document, however brief, the indications for and plan to pursue these surgeries.

a. On July 28, 2011, at 6:50 a.m., there was a note from Respondent indicating that a right frontal ventriculostomy was placed for decreased mental status due to GCS of 11 secondary to increase in hydrocephalus on the head CT of 07/28. Patient J.S. was subsequently taken to the operating room for suboccipital craniectomy and evacuation of the intracerebral hematoma on July 28, 2011 at approximately 12:00. However, there is no documentation from Respondent as to why a decision was suddenly made to take the patient to the operating room. Also, it is unclear why Respondent did not simply take the patient to the operating room at 6:50 a.m. If the plan was to operate on the patient, why place the ventriculostomy as a separate bedside event rather than performing the ventriculostomy along with the surgery at one time? In his deposition, Respondent's statements appear to imply that the interval from ventriculostomy placement to deterioration sufficient to convince the husband to pursue surgery was several days. He stated, "...as the days went by, even though she had a ventriculostomy, she was beginning to decline neurologically, from a GCS of 15 to a GCS of 13...." However, the chart does not verify this account.

b) Postoperatively, Patient J.S. was taken back to the operating room at approximately 20:47 for what Respondent documented as a "recurrent cerebellar intracerebral hemorrhage." However, the head CT performed after the first surgery does not indicate any evidence of a new or recurrent hemorrhage. It shows persistence of the previous hemorrhage which he elected not to evacuate

during the first surgery. The only subsequent documentation by Respondent on that date is a brief operative report on July 28, 2011, at 23:30. This note is brief and fails to indicate that two separate surgeries were performed. This appears to be a brief operative note on a single surgery. The notes include findings of briskly bleeding cerebellar vascular malformation but, at the same time, indicates there were no complications. It does not indicate that any specimen was sent to pathology, nor does the actual operative report. However, in his deposition testimony, Respondent states that he sent a specimen to pathology and obtained a preliminary read. He said, ". . . which I sent to pathology. They came back and said, 'This looks like it could be either an arterial venous malformation of a high grade fistula.'" The available records, however, do not contain any pathology reports whatsoever.

3) Regarding Patient J.S., failing to obtain an appropriate diagnostic study.

4) Regarding Patient J.S., misrepresenting or falsifying medical documents and/or misleading representatives of the Medical Board of California during the investigation of this case.

5) Regarding Patient J.L., the patient was taken to the operating room on September 21, 2011. This procedure was aborted due to an inability of the anesthesiologist to obtain IV access. Because the patient was taken to the operating room there should have been some documentation from the surgeon; there was none.

6) Regarding Patient J.L., two sets of medical records were obtained by representatives of the Medical Board of California. First, there were certified medical records provided by Southwest Healthcare Systems. In these records there was a continuity of the progress notes from the date of admission through the date of discharge. These records, however, did not contain any documentation from Respondent regarding the operative procedures. In the records later provided by Respondent, there was a different set of progress notes without explanation. Among other things, this set of records contains an asynchronous collection of the progress notes in which there is the note, dated September 21, 2011, from Respondent in the case managing discharge

planning notes as well as a brief operative note, dated September 24, 2011 with no time stamp or indication.

7) Regarding Patient J.L., extreme departure from the standard of care for repeatedly failing to document major clinical events, *i.e.*--major surgeries, in an appropriate and timely manner.

8) Regarding Patient J.L., an extreme departure for performing unnecessary surgery or, in the alternative, failing to document the need for the surgery.

9) Regarding Patient T.V., a physician should document within the daily progress notes of the patient's hospital chart the pertinent and specialty specific symptoms, signs, laboratory and radiographic diagnostic state along with an assessment of a specialty specific plan of care. Any major deleterious change in the patient's condition should be noted. The rationale for significant change in the patient's treatment plan, particularly a decision to proceed with surgery, should be documented however briefly within the daily progress note to facilitate appropriate care, allow other physicians involved in the care an understanding in the plan of care, and to keep an accurate account of the patient's course for medico-legal reasons.

10) Regarding Patient T.V., repeatedly failing to document major clinical events, i.e., surgery and neurological deterioration in an appropriate and timely manner.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

14. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he committed repeated negligent acts during his care, treatment and management of Patients J.S., J.L., and T.V., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 13, above, as though fully set forth.

B. The following acts and omissions constitute departures from the standard of care:

1) Regarding Patient J.S., a physician should document within the daily progress notes of the patient's hospital chart the pertinent and specialty specific symptoms, signs, laboratory and radiographic diagnostic data along with an assessment and specialty specific plan of care. Any major deleterious change in the patient's condition should be noted. Significant changes in the patient's treatment plan, particularly a decision to pursue surgery should be documented, however briefly, within the daily progress notes to facilitate appropriate care, allow other physicians involved in the care an understanding of the plan of care, and to keep an accurate account of the patient's course for medico-legal reasons.

2) Regarding Patient J.S., Respondent's documentation is grossly inadequate. Although in his Initial consultation note, dated July 25, 2011, Respondent noted a recommendation to pursue sub occipital craniotomy upon correction of the coagulopathy, a subsequent note on July 26, 2011, at 13:05, indicates that the patient has a stable intracerebral hemorrhage with increase in hydrocephalus and will need CSF diversion (ventriculostomy). Thus, the indications to pursue surgery are not clearly outlined in any of the documentation. Furthermore, there is no documentation in the progress record of him having performed two surgeries. The operative note for the first surgery was in fact dictated in September 2011, nearly six weeks after the surgery and well after the patient had expired. The operative note for the second surgery was dictated on August 18, 2011, which was approximately three weeks after the surgery and after the patient had expired. Thus, at the time of care it would appear that an uncomplicated single surgery was performed, when that was not in fact the case. Moreover, the cardiologist note from July 28, 2011, at 08:05 indicates that there may have been a change in the mental status after the ventriculostomy placement. The patient was noted to be unresponsive by the cardiologist. However, there was no documentation from Respondent to indicate a decline in the patient's mental status after the ventriculostomy placement that would prompt emergent sub occipital craniotomy. Based on the timings recorded in the progress record, Respondent had ample time between the placement of ventriculostomy in

the first surgery (nearly 3 hours) and between the first and second surgery (nearly 4 hours) to appropriately document, however brief, the indications for and plan to pursue these surgeries.

a. On July 28, 2011, at 6:50 a.m., there was a note from Respondent indicating that a right frontal ventriculostomy was placed for decreased mental status due to GCS of 11 secondary to increase in hydrocephalus on the head CT of 07/28. Patient J.S. was subsequently taken to the operating room for sub occipital craniotomy and evacuation of the intracerebral hematoma on July 28, 2011, at approximately 12:00 a.m. However, there is no documentation from Respondent as to why a decision was suddenly made to take the patient to the operating room. Also, it is unclear why Respondent did not simply take the patient to the operating room at 6:50 a.m. If the plan was to operate on the patient, why place the ventriculostomy as a separate bedside event rather than performing the ventriculostomy along with the surgery at one time? In his deposition, Respondent's statements appear to imply that the interval from ventriculostomy placement to deterioration sufficient to convince the husband to pursue surgery was several days. He stated, "...as the days went by, even though she had a ventriculostomy, she was beginning to decline neurologically, from a GCS of 15 to a GCS of 13...." However, the chart does not verify this account.

b) Postoperatively, Patient J.S. was taken back to the operating room at approximately 20:47 for what Respondent documented as a "recurrent cerebellar intracerebral hemorrhage." However, the head CT performed after the first surgery does not indicate any evidence of a new or recurrent hemorrhage. It shows persistence of the previous hemorrhage which he elected not to evacuate during the first surgery. The only subsequent documentation by Respondent on that date is a brief operative report on July 28, 2011, at 23:30. This note is brief and fails to indicate that two separate surgeries were performed. This appears to be a brief operative note on a single surgery. The notes includes findings of briskly bleeding

cerebellar vascular malformation but, at the same time, indicates there were no complications. It does not indicate that any specimen was sent to pathology, nor does the actual operative report. However, in his deposition testimony, Respondent states that he sent a specimen to pathology and obtained a preliminary read. He said, "... which I sent to pathology. They came back and said, 'This looks like it could be either an arterial venous malformation of a high grade fistula.'" The available records, however, do not contain any pathology reports whatsoever.

3) Regarding Patient J.S., failing to obtain an appropriate diagnostic study.

4) Regarding Patient J.S., misrepresenting or falsifying medical documents and/or misleading representatives of the Medical Board of California during the investigation of this case.

5) Regarding Patient J.L., The patient was taken to the operating room on September 21, 2011. This procedure was aborted due to an inability of the anesthesiologist to obtain IV access. Because the patient was taken to the operating room, there should have been some documentation from the surgeon; there was none.

6) Regarding Patient J.L., two sets of medical records were obtained by representatives of the Medical Board of California. First, there were certified medical records provided by Southwest Healthcare Systems. In this record there was a continuity of the progress notes from the date of admission through the date of discharge. These records, however, did not contain any documentation from Respondent regarding the operative procedures. However, in the records provided by Respondent, there is a different set of progress notes without explanation. Among other things, this set of records contains an asynchronous collection of the progress notes in which there is the note, dated September 21, 2011, from Respondent in the case managing discharge planning notes as well as a brief operative note, dated September 24, 2011 with no time stamp or indication.

7) Regarding Patient J.L., extreme departure from the standard of care for repeatedly failing to document major clinical events, *i.e.*, major surgeries, in an appropriate and timely manner.

8) Regarding Patient J.L., an extreme departure for performing unnecessary surgery or, in the alternative, failing to document the need for the surgery.

9) Regarding Patient T.V., A physician should document within the daily progress notes of the patient's hospital chart the pertinent and specialty specific symptoms, signs, laboratory and radiographic diagnostic state along with an assessment of a specialty specific plan of care. Any major deleterious change in the patient's condition should be noted. The rationale for significant change in the patient's treatment plan, particularly a decision to proceed with surgery, should be documented however briefly within the daily progress note to facilitate appropriate care, allow other physicians involved in the care an understanding in the plan of care, and to keep an accurate account of the patient's course for medico-legal reasons.

10) Regarding Patient T.V., repeatedly failing to document major clinical events, i.e. surgery and neurological deterioration in an appropriate and timely manner.

THIRD CAUSE FOR DISCIPLINE

(Dishonesty)

15. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (e), in that he committed dishonest or corrupts by creating false medical records and/or altering medical records pertaining to the provision of medical services to Patients J.S, J.L., T.V., and R.B. as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraph 13, above, as though fully set forth.

Patient R.B.

B. On or about May 22, 2013, the Medical Board of California's Central Complaint Unit (CCU) received a written patient complaint from Patient R.B. in which the

patient alleged that Respondent was negligent in the diagnosis of head injury sustained by R.B..

C. The medical records pertaining to Patient R.B.'s head injury were obtained.

D. Respondent was asked for and provided a written treatment summary of his care, treatment and management of Patient R.B. Thereafter, Respondent was interviewed by representatives of the Medical Board of California.

E. From the consumer complaint, Respondent's treatment summary, Respondent's interview, and the medical records relating to Patient R.B.'s head injury, the following was discerned:

1) Patient R.B., a resident of California, was involved in a major traffic accident in Texas in March 2013. Patient R.B. did not go to the emergency room at the time of the accident or upon his return to California. Patient R.B., however, began experiencing headaches, nausea, and dizziness. On April 12, 2013, Patient R.B. saw a Dr. N. as his own physician, Dr. M., was not available. Dr. N. order a CT scan. Patient R.B. then saw Dr. M. on April 15, 2013. Dr. M. advised that the CT scan appeared abnormal. Patient R.B. went to the emergency room where another CT scan was done. The second CT scan showed fluid on the brain, and Patient R.B. was admitted to Loma Linda University Hospital.

2) On April 17, 2013, Patient R.B. was seen by Respondent who made a diagnosis of subdural hygroma.

3) On April 29, 2013, Patient R.B. was supposed to see Respondent but, instead, was seen by M.M., Respondent's physician assistant, who prescribed Tylenol for the patient's pain and another CT scan. The following day, Patient R.B. underwent another CT scan. When Patient R.B. did not hear from Respondent, Patient R.B. saw another physician, Dr. Sh. who reviewed the most recent CT scan and then ordered that yet another CT scan be taken. Dr. Sh. referred the patient to Dr. St. who performed a craniotomy on May 21, 2013, without incident.

4) The entire matter was referred to an expert medical reviewer who determined that Respondent's records for Patient R.B. were false. According to Patient R.B., on April 29, 2013, he was seen by M.M., Respondent's physician assistant, not Respondent. Respondent's note for April 29, 2013, is authored and electronically signed only by Respondent. The records shows no indication that Respondent's physician assistant participated in the evaluation on that day. These particular records were updated and signed on October 23, 2013, two months after Respondent had become aware of Patient R.B.'s consumer complaint.

5) On April 21, 2014, Respondent signed a Declaration of Certification of Records indicating that he had no records for Patient R.B. in his office. On January 9, 2015, Respondent was deposed in the civil action brought against him by Patient R.B. In the deposition, Respondent averred: "I also have ... my surgical schedule for that day [--i.e., April 29, 2013], demonstrating that I was in fact in the operating room." However, when asked if the patient was seen by him or his physician assistant, Respondent replied, "He was seen by me."

6) Respondent's declaration that he did not have patient records for R.B. at his office notwithstanding, Respondent subsequently forwarded medical records from his office along with a Declaration of Certification of Records on January 21, 2015. The note documenting the April 29, 2013, visit was electronically signed on October 23, 2013, and indicates his Assessment/Plan as, "[Patient R.B.] remains neurologically intact and does not, at this time, require any neurosurgical operative or procedural intervention. [Patient R.B.] will be discharged back to the care of his primary medical doctor. I will , or course, be happy to follow-up with him in the future should the need arise."

7) The record created or altered for the April 29, 2013, visit was not consistent with the ensuing CT scan ordered by Respondent, Respondent's physician assistant, or some other member of Respondent's office and performed the following day at Health Scan Imaging.

F. Regarding Patient R.B., the following acts and omissions constitute violations of Business and Professions Code sections 2234, subdivision (e) (dishonest acts):

1) Creating a medical record showing that Respondent saw the patient on April 29, 2013, when in fact Respondent's physician assistant and only his physician assistant saw the patient on that day.

2) Altering a medical record for the purpose of showing that Respondent saw the patient on April 29, 2013, when in fact Respondent's physician assistant and only his physician assistant saw the patient on that day.

3) Executing a declaration under the penalty of perjury that the medical records for Patient R.B. were true and accurate.

4) Advising representatives of the Medical Board of California that he, Respondent, did not have any office medical records for Patient R.B.

FOURTH CAUSE FOR DISCIPLINE

(Creating False Medical Records)

16. Respondent is subject to disciplinary action under Business and Professions Code section 2261 in that Respondent created false medical records pertaining to the provision of medical services to Patients J.S, J.L., T.V. , and R.B., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 13 and 15, above, as though fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Altering Medical Records)

17. Respondent is subject to disciplinary action under Business and Professions Code section 2262 in that Respondent altered medical records pertaining to the provision of medical services to Patients J.S., J.L., T.V., and R.B., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 13 and 15, above, as though fully set forth.

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SIXTH CAUSE FOR DISCIPLINE

(Failure To Maintain Adequate and Accurate Medical Records)

18. Respondent is subject to disciplinary action under Business and Professions Code section 2266 in that Respondent failed to maintain adequate and accurate records pertaining to the provision of medical services to Patients J.S., J.L, T.V., and R.B., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 13 and 15, above, as though fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

19. Respondent is subject to disciplinary action under Business and Professions Code section 2234 in that Respondent committed unprofessional conduct, generally, during his care, treatment and management of Patients J.S, J.L., T.V., and R.B., as follows:

A. Complainant refers to and, by this reference, incorporates herein paragraphs 13 and 15, above, as though fully set forth.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 68609, issued to MARK A. SPICER, M.D.;

2. Revoking, suspending or denying approval of MARK A. SPICER, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering MARK A. SPICER, M.D., if placed on probation, to pay the Medical Board of California the costs of probation monitoring; and,

4. Taking such other and further action as deemed necessary and proper.

DATED: December 14, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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